Uniform Medical Plan
Your health. Your plan. Your choice.

Volume 1, Issue 1 **Provider Bulletin** Sept. 1999

Please circulate the UMP *Provider Bulletin* to the appropriate medical, billing, and bookkeeping staff.

A Personal Note from Andrew Brunskill, M.D., Medical Director

On behalf of the Uniform Medical Plan (UMP), I am pleased to introduce our UMP Provider Bulletin.

The UMP, administered by the Washington State Health Care Authority (HCA), is the one plan offered to all state employees and retirees offering maximum freedom of choice.

Our motto for the UMP:

"Your Health. Your Plan. Your Choice."

is intended to apply for *both* our enrollees and our providers. We do hear clearly—from *both* our enrollees and from you—that maximum freedom for clinical practice, for referrals, for prescriptions, and for similar clinical autonomy is important for patient satisfaction and for you to be able to obtain the best results for each patient individually! We are committed to working to maximize these clinical freedoms and to continue to emphasize both quality and value.

The UMP has one of the largest preferred provider networks in the state of Washington. It has a comprehensive benefit structure and a pharmacy design that maximizes freedom of choice to our enrollees—your patients—and to you. We recognize that to maintain these elements of maximum freedom of choice, and *still* remain financially viable, we will need to develop better ways to provide clinically helpful information to both you and our enrollees. We are committed to this.

Periodically, these UMP *Provider Bulletins* will include articles from me pertaining to our plan and to clinical issues. I will try to answer issues or requests that you have identified and will welcome an opportunity to discuss any issue or concern, or to hear suggestions you may have on how we can improve.

Thank you for helping us keep our plan focused on and working to provide maximum freedom of choice.

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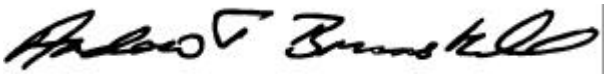

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How To Reach Us

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Fax 425-670-3199

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- Customer Service
- Claims Information
- Enrollee Eligibility Information
- Medical Review
- Prenotification/Preauthorization

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Fax 425-521-2001

- Change of Provider Status
- New Provider Enrollment
- Provider Contract Information

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- Fee Schedule Information
- Policies and Procedures
- Training Support
- *Provider Bulletin* Feedback

UMP Web Site **www.wa.gov/hca/ump**

Updated Fee Schedule for Professional Providers

Effective July 1, 1999

The UMP Fee Schedule for Professional Providers was updated on July 1, 1999. Details pertaining to the revised maximum allowances are included below.

Maximum Allowances Based on Resource Based Relative Value Scale (RBRVS) Methodology

The maximum allowances for most codes are based on the Health Care Financing Administration's (HCFA) 1999 relative value units, HCFA's 1999 statewide Geographic Practice Cost Indices (GPCIs) for Washington, and the UMP's revised RBRVS conversion factor of $45.55. Although the conversion factor changed from $46.21 to $45.55 with the July 1, 1999 update, the maximum allowances for many of the codes increased with the implementation of the 1999 relative value units (RVU).

Maximum Allowances Based on Medicare's Clinical Diagnostic Laboratory Fee Schedule

The maximum allowances for clinical laboratory procedure codes (with the exception of Pap smears) are set at 136.5 percent of Medicare's 1999 Clinical Diagnostic Laboratory Fee Schedule. Many of the UMP maximum allowances for clinical laboratory procedure codes did not change with this update as a result of a provision of the Balanced Budget Act of 1997, which provided no inflation update to Medicare's Clinical Diagnostic Laboratory Fee Schedule for 1999.

The UMP increased the maximum allowances for the conventional Pap smear codes to $13.00 and set the thin layer preparation Pap smear codes at $25.00, for dates of service on or after July 1, 1999. The revised UMP maximum allowances for the Pap smear codes are subject to further review and refinement if HCFA updates the Medicare fees and/or when input is received from the Clinical Laboratory Advisory Council (CLAC) pertaining to the direct and indirect costs to perform Pap smears.

Maximum Allowances Based on Medicare's Durable Medical Equipment/Prosthetic and Orthotic Fee Schedule

Many supply items on the UMP Fee Schedule for Professional Providers are considered "bundled" into the cost of other services and are not paid separately. The maximum allowances for prosthetic and orthotic codes (including ostomy and urological codes) which are not bundled are equal to the amounts on the UMP Prosthetic and Orthotic Fee Schedule for Suppliers. Refer to page 4 for information related to the Supplier Fee Schedule update.

New and Revised Payment Policies

Effective July 1, 1999

Drugs and Biologicals Administered by the Provider (HCPCS Level II J-codes and Q-codes)

The UMP changed the payment policy for reimbursement of covered drugs and biologicals administered by the provider in the office setting. Rather than continuing with the payment policy based on acquisition cost (billed charges), the UMP adopted HCFA's payment policy based on 95 percent of Average Wholesale Prices (AWP) effective July 1, 1999.

The UMP maximum allowances for most of the HCPCS level II drug and biological J-codes and Q-codes are set at the Medicare fee schedule amounts determined and published by the Part B Medicare Carrier for Washington. For codes where the Medicare Carrier has not established a fee, the UMP will determine the maximum allowances for covered drugs using the current Red Book and following methodology:

Pricing Methodology

1. For a single-source drug or biological, the AWP equals the AWP of the single product.

2. For a multi-source drug or biological, the AWP is equal to the lesser of the median AWP of all of the generic forms of the drug or biological or the lowest brand name product AWP. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

3. After determining the AWP according to #1 and #2 above, the amount is multiplied by 0.95 to arrive at the fee schedule maximum allowance.

When billing for the drugs and biologicals, providers must follow the descriptions of the HCPCS level II codes and include the correct number of units on the claim form for appropriate reimbursement by the UMP. Unclassified or unspecified drug codes should be billed only when there is not a specific code for the drug being administered. The name, manufacturer, strength, dosage, and quantity of the drug must be included with the unclassified or unspecified drug code for coverage and payment consideration.

Note that codes J8499 and J8999 for oral prescription drugs are not covered on the UMP Fee Schedule for Professional Providers.

Additional Bundled Procedure Code under RBRVS Methodology

After changing procedure code R0076 (transportation of portable EKG equipment) from a bundled service to a non-bundled service last year, HCFA changed it back to a bundled service this year. Following HCFA's revised payment policy, the code R0076 is bundled and not separately payable by the UMP under the RBRVS methodology for dates of service on or after July 1, 1999.

Procedures Eligible for Separate Reimbursement of a Surgical Tray (A4550) and Specified Supplies (A4263, A4300, G0025)

There are no additions or deletions to the list of procedure codes eligible for separate reimbursement of a surgical tray (A4550) and specified supplies (A4263, A4300, and G0025) published in the *UMP Billing and Administrative Billing Manual* at this time.

The UMP maximum allowances for the surgical tray code and specified supply codes decreased with the July 1, 1999 update due to a reduction in HCFA's relative value units this year. HCFA intends to eventually discontinue separate payment for the surgical tray and the specified supply codes as the costs are being factored into HCFA's new resource-based practice expense RVUs for the procedures, which are being transitioned in over a four year period (1999-2002). The payment for the surgical tray and specified supply codes will be phased out by HCFA as the new resource-based practice expense RVUs are transitioned in.

Positron Emission Tomography (PET) Scans

The UMP Medical Director determines coverage decisions for all PET scans on a case-by-case pre-authorization basis (or appeal basis). Medical records justifying the medical necessity must be submitted for the coverage determination.

When coverage is approved, the UMP maximum allowance for the PET scan is based on HCFA's 1999 RVUs, HCFA's statewide GPCIs and the UMP RBRVS conversion factor for dates of service on or after July 1, 1999. UMP maximum allowances for PET scan codes where HCFA has not established RVUs are determined on a "by report" basis.

Teleconsultation Services (Reported with Modifier GT)

Coverage decisions for teleconsultation services are determined by the UMP on a case-by-case basis. Medical records justifying the medical necessity for the telemedicine service must be submitted for any coverage and payment consideration.

Medical Direction of Anesthesia Services

The UMP adopted HCFA's payment policy for medical direction of anesthesia services. Under the payment policy, physicians directing qualified individuals performing anesthesia must:

- perform a pre-anesthetic examination and evaluation;
- prescribe the anesthesia plan;
- personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
- ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions;
- monitor the course of anesthesia administration at frequent intervals;
- remain physically present and available for immediate diagnosis and treatment of emergencies; and
- provide indicated post-anesthesia care.

In addition, the physician may direct no more than four anesthesia services concurrently and may not perform any other services while directing the single or concurrent services. The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

The physician must document in the patient's medical record that the medical direction requirements were met. While the physician does not need to submit this documentation with the claim, the medical records must be available to the UMP upon request.

Anesthesia Payment System Update

Effective July 1, 1999

The UMP anesthesia payment system was updated with St. Anthony's 1999 Relative Values for Physicians anesthesia base units on July 1, 1999. The UMP anesthesia conversion factor is $2.9167 per minute, or $35.00 per 12 minutes. Anesthesia time must be billed in one-minute units for appropriate reimbursement.

Update to Prosthetic and Orthotic Fee Schedule for Suppliers

Effective July 1, 1999

The UMP Prosthetic and Orthotic Fee Schedule for Suppliers (including ostomy and urological supplies) was updated on July 1, 1999. The updated maximum allowances are based on Medicare's 1999 Durable Medical Equipment/Prosthetic and Orthotic Fee Schedule.

Y2K Update

The Health Care Authority contracts with CENTRA Benefit Services to provide administrative services on behalf of the UMP. CENTRA's objective with regards to Year 2000 compliance is to provide uninterrupted services to all its customers, while maintaining a high level of service.

In addition to CENTRA's Year 2000 system compliance efforts, a comprehensive contingency

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plan has been developed to continue business operations in case of system or building failures. The plan includes manual claims processing, remittance production and distribution, as well as simple operations functions such as building access and multiple forms of continued communication.

In order to best serve their customers, CENTRA will do whatever is needed to ensure that operations remain timely and efficient upon the advent of January 1, 2000.

Private Contracts with Medicare Beneficiaries to "Opt Out" of the Medicare Program

The private contracting provision of the Balanced Budget Act of 1997 allows certain physicians and practitioners to "opt out" of the Medicare Program and provide services through private contracts that would otherwise be covered by Medicare.

Effective January 1, 2000, services rendered under private contracts by providers who "opt out" of Medicare will not be reimbursed by the UMP. In a private contract situation, the UMP enrollee will be solely responsible for the provider's total billed charges.

The UMP intends to notify enrollees in its October 1999 open enrollment materials that the UMP does not cover, nor can such charges be applied to any required UMP deductible or out-of-pocket limit when Medicare coverage is primary, and charges are submitted for services or supplies provided to enrollees through a "Private Contract" agreement with a physician or practitioner who does not provide services through the Medicare program.

Until January 1, 2000, the UMP will pay covered services rendered by providers who "opt out" of Medicare where a private contract exists on a primary payer basis.

Global Surgery Payment Rules Reminder

The UMP continues to follow the Health Care Finance Administration's (HCFA's) national definition of a global surgical package, in which a single fee is billed and paid for all necessary services, normally furnished by the surgeon before, during, and after the procedure.

Under the payment policy, major procedures have a 90-day postoperative period, and minor procedures have a zero- or 10-day postoperative period. UMP's payment policy differs from HCFA's by having a 45-day postoperative period for some maternity care and delivery codes based on provider input and discussions between the State Agency Technical Advisory Group (TAG) and the Interagency Reimbursement Steering Committee (RSC). The TAG, consisting of representatives for the Washington State Medical Association (WSMA) and all other major provider groups, provides ongoing input on reimbursement and other health care issues to the RSC, which represents the Health Care Authority's UMP, Department of Labor and Industries (L&I), and Medical Assistance Administration (MAA).

Claims for services or supplies that may be separately payable within the preoperative or postoperative period of a procedure must contain the diagnosis codes and appropriate CPT code modifier (such as 24, 25, 57, 78, or 79) as applicable for payment consideration. Supporting documentation must be provided when required or requested by the UMP to make a payment determination in this circumstance.

If you are unsure of what services and supplies are included in the global payment for the procedure and should not be billed separately, please refer to the *UMP Billing and Administrative Manual* for professional providers (last updated June 1998) that was sent to your office.

Notifying UMP of Changes

It is important to keep us informed of any changes to a preferred provider's status, such as business addresses, telephone numbers, tax identification numbers, licensure, certification, registration, or qualifications. Updated provider information should be provided to the UMP Provider Credentialing Division. See page 2 of this bulletin for contact information.

The UMP *Provider Bulletin* is published 2-3 times per year by the Washington State Health Care Authority Uniform Medical Plan to inform our providers about important plan news and changes.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY/TDD users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

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